Department of Veterans Affairs
Office of Inspector General
October 2015 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies on Inappropriate Use of Position and Misuse of Relocation Program and Incentives at Veterans Benefits Administration

Linda A. Halliday, Deputy Inspector General, testified at a hearing before the Committee on Veterans' Affairs, United States House of Representatives, on the results of the Office of Inspector General's (OIG) recently published report on the use of VA's relocation program and related incentives within the Veterans Benefits Administration (VBA). Ms. Halliday explained that her statement was limited in order to preclude any allegation that OIG's testimony could unduly influence VA or the Department of Justice regarding potential administrative or criminal action. She told the Committee that the report concluded VBA misused the permanent change of station (PCS) program for the benefit of its senior executive service workforce and that VA needs to take actions to strengthen controls over, and oversight of, the PCS program in order to improve the financial stewardship of taxpayer funds. She also noted that effective October 1, 2015, VA ceased offering the Appraised Value Offer component of its PCS program which helps employees sell their primary residences. Ms. Halliday was accompanied by Mr. Nicholas Dahl, Director, Bedford Office of Audits and Evaluations, and Ms. Linda Fournier, Director, Administrative Investigations Division.
[Click here to access testimony.]

OIG REPORTS

Review Substantiates Delay in a Surgical Consult at Oxnard, California, Clinic, Delays in Neurology Consults Also Found

OIG conducted an inspection at the request of Representative Julia Brownley to assess the merit of allegations regarding a delay in a surgical consult at the Oxnard Community Based Outpatient Clinic (CBOC), VA Greater Los Angeles Healthcare System (system), Los Angeles, CA, that may have resulted in the death of a patient in August 2012. The complainant alleged that a veteran experienced a delay in surgical consultation for placement of a feeding tube and that the delay resulted in the veteran's death. OIG substantiated that the patient experienced a delay in obtaining a surgical consult to address his complaints of dysphagia, or difficulty swallowing. OIG determined that this delay resulted from the primary care provider's failure to diagnose the patient's dysphagia timely and/or failure to coordinate the patient's care by following up on the requested neurology consult, as well as the neurologist's failure to classify the July 2012 surgical consult as urgent. OIG could not substantiate that the patient died as a result of the failure to address his dysphagia. The patient did not die in a hospital, and OIG found no indication that an autopsy was performed. In the course of the review, OIG found that the system had significant numbers of neurology consults open longer than 90 days. System staff explained that this resulted from a failure to close consults properly after the patients had been seen. However, OIG determined that the next available appointment in the neurology clinic was approximately 6 weeks in the future,

suggesting that some patients may experience delays in obtaining timely neurology consults. OIG made three recommendations. [Click here to access report.]

Phoenix Health Care System Leaders Did Not Plan or Respond Adequately to Urology Shortage,10 Patients Placed at Unnecessary Risk

OIG conducted an inspection to evaluate access to care concerns in the Urology Service at the Phoenix VA Health Care System (PVAHCS), Phoenix, AZ. OIG determined that PVAHCS leaders did not have a plan to provide urological services during unexpected provider shortages in the Urology Service. PVAHCS leaders did not promptly respond to the staffing crisis, which may have contributed to patients being "lost to follow-up" and staff frustration due to lack of direction. OIG determined that non-VA providers' clinical documents were not available for PVAHCS providers to review timely. OIG concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to non-VA clinical records. OIG also concluded that PVAHCS Urology Service and Non-VA Care Coordination staff did not provide timely care or ensure timely urological services were provided to patients needing care. OIG identified 10 patients who experienced significant delays that may have affected their clinical outcomes in some instances. Such delays placed patients at unnecessary risk for adverse outcomes. OIG found that the quality of non-urological care in two cases was not acceptable, which placed these patients at unnecessary risk for harm. OIG recommended the PVAHCS Interim Facility Director ensure that: (1) resources are in place to deliver timely urological care to patients; (2) non-VA care providers' clinical documentation is available in VA electronic health records in a timely manner for review; and (3) cases identified in this report are reviewed, and for patients who suffered adverse outcomes and poor quality of care, confer with Regional Counsel regarding the appropriateness of disclosures to patients and families. [Click here to access report.]

Combined Assessment Program Reviews

In October 2015, OIG published three Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following 13 activities:

(1) Quality Management
(2) Environment of Care
(3) Medication Management
(4) Coordination of Care
(5) Computed Tomography Radiation Monitoring
(6) Advanced Directives
(7) Surgical Complexity
(8) Emergency Airway Management
(9) Continuity of Care
(10) Mammography Services

(11) Suicide Prevention Program
(12) Management of Workplace Violence
(13) Mental Health Residential Rehabilitation Treatment Program

Alaska VA Healthcare System, Anchorage, Alaska
Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
Marion VA Medical Center, Marion, Illinois

CBOC Reviews
In October 2015, OIG published three CBOC reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate five operational activities:

(1) Environment of Care
(2) Alcohol Use Disorder Care
(3) Human Immunodeficiency Virus Screening
(4) Outpatient Documentation
(5) Outpatient Lab Results Management

Marion VA Medical Center, Marion, Illinois
Battle Creek VA Medical Center, Battle Creek, Michigan
VA New Jersey Health Care System, East Orange, New Jersey

CRIMINAL INVESTIGATIONS

Former VA Fiduciary Sentenced for Misappropriation
A former VA fiduciary was sentenced to 366 days' incarceration, 2 years' supervised release, and was ordered to pay full restitution (amount to be determined) after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed that the defendant, who worked as an assisted living facility administrator, stole the disability benefits of a veteran residing in the facility. The loss to the veteran is $293,952.

Former VA Fiduciary Sentenced for Misappropriation of VA and Social Security Benefits
A former VA fiduciary was sentenced to 18 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $109,066 after pleading guilty to misappropriation by a fiduciary and converting of a Social Security benefit. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the fiduciary stole funds from two veterans while acting as their fiduciary.

Former VA Fiduciary Pleads Guilty to Theft of Government Funds
A former VA fiduciary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report to VA that his son had been incarcerated and during that time the defendant used the VA funds for personal expenses. The loss to VA is $69,686.

Veteran Indicted for Health Care Fraud and False Statements
A veteran was indicted for health care fraud and false statements relating to health care fraud. An OIG investigation revealed that the defendant made false statements regarding his mental health condition that resulted in his receiving special monthly compensation from 1999 to 2013 that he was not entitled to receive. The loss to VA is $156,925.

Former Montrose, New York, VA Medical Center Union President Indicted for Wire Fraud and False Statements
A former Montrose, NY, VA Medical Center (VAMC) American Federation of Government Employees President was indicted for wire fraud and false statements. An OIG and Department of Labor Office of Labor-Management Standards investigation revealed that the defendant used a union debit card to withdraw money and incur charges for personal use. The loss to the union is approximately $120,000.

Settlement of Health Care Fraud Scheme Will Return Funds to VA for Continued Care of Veterans
A former district manager for a major pharmaceutical company pled guilty to conspiracy to commit health care fraud. The defendant is also subject to criminal forfeiture proceedings. A VA OIG, Food and Drug Administration (FDA) Office of Criminal Investigation (OCI), Federal Bureau of Investigation, Health and Human Services OIG, Defense Criminal Investigative Service, and Office of Personnel Management OIG investigation revealed that the defendant instructed sales representatives reporting to him to manipulate documents submitted to managed care companies. The sales representatives submitted "canned" medical justifications even if the justification they submitted did not match the actual health history of the patients involved. Furthermore, the defendant instructed sales representatives to fill out the forms on behalf of medical providers and to alter handwriting to avoid detection.

Hot Springs, South Dakota, VAMC Employee Pleads Guilty to Assault
A Hot Springs, SD, VAMC employee pled guilty to assault of a Federal employee. An OIG investigation revealed that the defendant threatened to shoot a VA police officer and grabbed and exposed himself to a VA nurse while receiving medical care at the facility.

Former White River Junction, Vermont, VAMC Canteen Chief Sentenced for Theft
The former White River Junction, VT, VAMC canteen chief was sentenced to 1 to 3 years' suspended sentence, 30 days' on a pre-approved furlough work crew, and was ordered to pay restitution of $1,320 after pleading guilty to false pretenses. An OIG investigation revealed that in 2013 the defendant falsified canteen petty cash records to make it appear as though the funds had been spent on office supplies when, in fact, they were used for her personal expenses.

Albany, New York, VAMC Nurse Faces Prison Time, Fine if Convicted for Tampering With Oxycodone Syringes
A former Albany, NY, VAMC hospice nurse was arrested after being indicted for tampering with a consumer product and obtaining a controlled substance by deception and subterfuge. An OIG and FDA OCI investigation revealed that for approximately 4 months the defendant removed oxycodone from the Pyxis machines on the hospice ward and replaced it with haloperidol, an anti-anxiety medication that is also used to treat involuntary movement. The medication substitution may have potentially caused pain and suffering for up to 44 veterans who were patients on the ward.

Buffalo, New York, VAMC Nurse Arrested for Drug Diversion
A Buffalo, NY, VAMC licensed practical nurse was arrested for diversion of controlled substances (hydromorphone). An OIG investigation revealed that the defendant had been stealing doses of hydromorphone since January 2015 by exploiting lax waste procedures on her ward. The defendant would remove a hydromorphone ampule from the Pyxis machine larger than the patient's prescribed amount, administer the patient's prescribed dose, then draw the remainder of the ampule into an insulin syringe for her own use.

Former Manchester, New Hampshire, VAMC Pharmacist Indicted for False Statements
A former Manchester, NH, VAMC pharmacist was indicted for false statements. An OIG and VA Police Service investigation, initiated as a result of a possible drug diversion, revealed that the defendant failed to disclose on his employment application that he was terminated by two prior employers for gross misconduct related to suspected diversion and lack of clinical competence.

Non-Veteran Sentenced for Drug Distribution at Canandaigua, New York, VAMC
A non-veteran was sentenced to 4 months' incarceration and 5 years' probation after pleading guilty to the criminal sale of a controlled substance and criminal possession of a controlled substance. An OIG and local sheriff's office investigation revealed that the defendant brought 4 grams of crack cocaine to the Canandaigua, NY, VAMC with the intent to sell to a veteran who was undergoing substance abuse treatment.

Non-Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft in Las Vegas, Nevada
A non-veteran was indicted for theft of Government funds and aggravated identity theft. The defendant was subsequently located and arrested at his residence in Las Vegas, NV. An OIG investigation revealed that the defendant, using the name of an actual veteran, diverted monthly VA compensation benefits by use of a fraudulently established eBenefits account. The defendant also applied for and was granted health care benefits in 2011 by using the veteran's identity. The loss to VA is approximately $42,000.

Daughter of Deceased VA Beneficiary Sentenced for Mail Fraud and Theft
The daughter of a deceased VA beneficiary was sentenced to 6 months' home confinement, 5 years' probation, and was ordered to pay restitution of $110,354 to VA and $62,876 to SSA after pleading guilty to mail fraud and theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated her deceased mother's VA and SSA benefit checks after her mother's death in June 2005.

Niece of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The niece of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA Dependency and Indemnity Compensation benefits that were direct deposited after her aunt's death in July 2007. The loss to VA is $107,452.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds
The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death and then stole VA benefits that were direct deposited after her mother's death in December 2009. The loss to VA is $86,281.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds
The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in July 2009. The loss to VA is approximately $77,000.

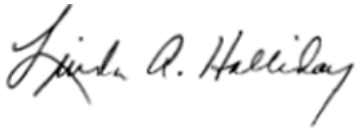
Daughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated her mother's VA benefit checks after her mother's death in February 2007. The defendant admitted to using the VA funds for personal expenses. The loss to VA is approximately $66,000.

Daughter of Deceased VA Beneficiary Sentenced for Theft
The daughter of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay restitution of $63,197. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in September 2005. The defendant admitted to using the VA funds for personal expenses.

Non-Veteran Sentenced for Theft of VA Health Care Benefits
A non-veteran was sentenced to 15 months' incarceration, 3 years' probation, and was ordered to pay nearly $30,000 in restitution for receiving VA health care benefits that she was not entitled to receive. An OIG investigation revealed that the defendant falsely claimed to have served in the Army National Guard from 1996 to 2010, to suffer from post-traumatic stress disorder, and to have served in combat during two tours in

Afghanistan. The defendant never served in the military and was incarcerated during the same time period that she claimed to have been in the military. For over 2 years, the defendant received VA health care benefits in addition to non-VA care paid by VA. The defendant also fraudulently received more than 10,000 milligrams of oxycodone from VA.

Funeral Home Director Arrested for Filing False Claims
A funeral home director was arrested for filing false claims to VA. An OIG investigation revealed that the defendant submitted numerous fraudulent claims for reimbursement to VA for burial and transportation services that were never provided to the families of deceased veterans who were participants in a university's anatomical gift program. The veterans had donated their bodies to medical research, and their remains were returned directly to their families after cremation by the university.



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